Complete Summary

GUIDELINE TITLE

Guidelines for the management of herpes simplex virus in pregnancy.

BIBLIOGRAPHIC SOURCE(S)

Money D, Steben M, Society of Obstetricians and Gynaecologists of Canada. Guidelines for the management of herpes simplex virus in pregnancy. J Obstet Gynaecol Can 2008 Jun;30(6):514-9. [43 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Maternal primary and recurrent genital herpes simplex virus (HSV) infection
- Neonatal and congenital HSV infection

GUIDELINE CATEGORY

Counseling
Diagnosis
Management
Prevention
Treatment

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To provide recommendations for the management of genital herpes infection in women who want to get pregnant or are pregnant and for the management of genital herpes in pregnancy and strategies to prevent transmission to the infant

TARGET POPULATION

Women who want to get pregnant or are pregnant and have genital herpes simplex virus (HSV) infection

INTERVENTIONS AND PRACTICES CONSIDERED

Counseling/Evaluation/Diagnosis

1. Medical history and physical examination
2. Counseling women about the risks of transmission of genital herpes to their neonates at delivery
3. Type-specific serology testing if indicated

Management/Treatment/Prevention

1. Acyclovir or valacyclovir suppression at 36 weeks' gestation
2. Consider elective Caesarean section

MAJOR OUTCOMES CONSIDERED

Effect of antiviral treatment on the risk of viral shedding, need for Cesarean section, and neonatal herpes

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline was searched for articles published in French or English related to genital herpes and pregnancy. Additional articles were identified through the references of these articles. All study types and recommendation reports were reviewed.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence from well-designed controlled trials without randomization

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Classification of Recommendations*

A. There is good evidence to recommend the clinical preventive action.

B. There is fair evidence to recommend the clinical preventive action.

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.

D. There is fair evidence to recommend against the clinical preventive action.

E. There is good evidence to recommend against the clinical preventive action.

I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This guideline has been reviewed by the Infectious Disease Committee and the Maternal Fetal Medicine Committee and approved by the Executive and Council of the Society of Obstetricians and Gynecologists of Canada.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the levels of evidence (I, II-1, II-2, II-3, and III) and grades of recommendations (A-E and I) are provided at the end of the "Major Recommendations" field.

1. Women's history of genital herpes should be evaluated early in pregnancy. (**III-A**)

2. Women with known recurrent genital herpes simplex virus (HSV) should be counselled about the risks of transmission of HSV to their neonates at delivery. (**III-A**)
3. At delivery, women with recurrent HSV should be offered a Caesarean section if there are prodromal symptoms or in the presence of a lesion suggestive of HSV. (**II-2A**)
4. Women with known recurrent genital HSV infection should be offered acyclovir or valacyclovir suppression at 36 weeks' gestation to decrease the risk of clinical lesions and viral shedding at the time of delivery and therefore decrease the need for Caesarean section. (**I-A**)
5. Women with primary genital herpes in the third trimester of pregnancy have a high risk of transmitting HSV to their neonates and should be counselled accordingly and should be offered a Caesarean section to decrease this risk. (**II-3B**)
6. A pregnant woman who does not have a history of HSV but who has had a partner with genital HSV should have type-specific serology testing to determine her risk of acquiring genital HSV in pregnancy, before pregnancy or as early in pregnancy as possible. Testing should be repeated at 32 to 34 weeks' gestation. (**III-B**)

Definitions:

Quality of Evidence Assessment*

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Classification of Recommendations**

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E. There is good evidence to recommend against the clinical preventive action.

I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

**Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of complications of genital herpes in pregnancy and prevention of transmission of genital herpes from mother to infant

POTENTIAL HARMS

Use of acyclovir in pregnancy has not been associated with any consistent pregnancy complications or fetal/neonatal adverse effects, other than transient neutropenia.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Jun

GUIDELINE DEVELOPER(S)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Obstetricians and Gynaecologists of Canada

GUIDELINE COMMITTEE

Infectious Disease Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Society of Obstetricians and Gynaecologists of Canada Web site.

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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